HEALTH INSURANCE FOR THE AGED
PROVIDER REIMBURSEMENT MANUAL

2100. PRINCIPLE

All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries or, in the case of acute care hospitals, the prospective payment system (PPS). (See Chapter 28 on PPS.) Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

2102. DEFINITIONS

2102.1 Reasonable Costs.--Reasonable costs of any services are determined in accordance with regulations establishing the method or methods to be used, and the items to be included. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. The objective is that under the methods of determining costs, the costs for individuals covered by the program are not borne by others not so covered, and the costs for individuals not so covered are not borne by the program.

Costs may vary from one institution to another because of scope of services, level of care, geographical location, and utilization. It is the intent of the program that providers are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors. Utilization, for this purpose, refers not to the provider's occupancy rate but rather to the manner in which the institution is used as determined by the characteristics of the patients treated (i.e., its patient mix - age of patients, type of illness, etc.).

Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. (See §2103.) If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

In the event that a provider undergoes bankruptcy proceedings, the program makes payment to the provider based on the reasonable or actual cost of services rendered to Medicare beneficiaries and not on the basis of costs adjusted by bankruptcy arrangements.

2102.2 Costs Related to Patient Care.--These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

2102.3 Costs Not Related to Patient Care.--Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

Such costs are not allowable in computing reimbursable costs and include, for example:

- o Cost of meals sold to visitors;
- o Cost of drugs sold to other than patients;
- o Cost of operation of a gift shop;

2l50.HOME OFFICE COSTS--CHAIN OPERATIONS

A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care. (See §§l002.2 and l002.3 for definitions of common ownership and control.)

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicare program is that of a related organization to participating providers. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.

Very often the home office of a chain organization charges the providers in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, except where §l0l0 is applicable, and such fees must be deleted from the provider's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the provider. The instructions for preparation of a home office cost statement containing schedules for the determination of home office costs and equity capital, and their allocation, are set forth in §2l53.

Section 2l50 is not applicable to franchise fees (see §2135ff), management fees or fees for other services paid by a provider where there is no common ownership or control between the provider and the franchisor or other service organization, or where the exception to the related organization principle applies (see §l0l0).

2l50.l General Limitation on Allowability of Costs.--Where a provider is furnished services, facilities, or supplies from an organization related to it by common ownership or control, the costs allowed are subject to the provisions of chapter l0. Thus, allowable cost is limited to the lower of (l) allowable costs properly allocated to the provider, except as indicated in §l0l0, or (2) the price for comparable services, facilities, or supplies that could be purchased elsewhere, taking account of the benefits of effective purchasing that would accrue to each member provider because of aggregate purchasing on a chainwide basis.

2l50.2 Determination of Allowable Costs.--

A. General.--Home office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.) are allowable to the extent they are reasonable (see §2l02.l). Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. For example, certain advertising costs (see §2l36.2), some franchise taxes and other similar taxes (see §2l22.4), costs of noncompetition agreements (see §2l05.l), certain life insurance premiums (see §2l30), certain membership costs (see §§2l38.3 and 2l38.4) or those costs related to nonmedical enterprises are not considered allowable home office costs. In addition, where an owner of the provider, as defined in chapter 9, received compensation for services provided by the home office, the compensation is allowable only to the extent that it is related to patient care (see §902.2) and to the extent that it is reasonable (see §902.3).

B. Organization, Start-Up, and Other Corporate Costs.--

l. Organization Costs.--The organization costs of a home office (except those referred to below) are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions in §2l34ff. Section 2l34.lB describes costs which are not considered allowable organization costs. In addition, reorganization costs (see §2l34.l0) and stockholder servicing costs (see §2134.9) are not allowable organization costs. These unallowable organization costs are excluded from the computation of the home office equity capital.

2. Start-Up Costs.--Start-up costs of a home office are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions of §2l32ff.

3. Costs of Corporate Acquisitions.--Costs related to the acquisition of the capital stock of a provider, whether or not such facilities are participating or subsequently will participate in the Medicare program, are not allowable (see §2l34.ll). Additionally, costs connected with the transfer of assets to a chain are not allowable as organization costs but instead must be capitalized as part of the cost of the asset (see §l04.l0).

C. Interest on Loans Between Home Office and Components of Chain.--Where the home office makes a loan to, or borrows money from, one of the components of the chain, the interest paid is generally not an allowable cost and the interest income earned from such a loan is not used to reduce allowable interest expense. (See §2l8 for the general rule and §§218.2 and 220 for exceptions to the general rule.)

2l56. ALLOWABLE COSTS OF GOVERNMENTAL SUPPORT SERVICES TO STATE AND LOCAL GOVERNMENTAL PROVIDERS

Agencies and departments of State and local governments often furnish providers operated by such government with facilities and services necessary to the operation of those providers. These facilities and services included such items as motor pool, legal counsel, procurement personnel administration, data processing payroll, maintenance and operation of plant, accounting, budgeting, auditing, and mail and messenger services. The costs of such facilities and services are includable in the allowable costs of the provider to the extent they are (l) reasonable, (2) related to patient care, (3) allowable under Medicare regulations, and (4) allocated on an acceptable basis.

Allowable services may also include an allocable share of supportive and supervisory time directly present in furnishing the service to the provider. They should not include supervision of a general nature such as that of a department head or staff assistants not directly involved in specific operations.

Any grants, Federal or private or gifts received by State and local government for operating expenses must be offset against allowable costs.

2l56.l Unallowable Central Service Costs.--The following expenses are unallowable: (l) general administrative costs of State and local governments-such as the general expenses of State and local governments in carrying out the coordinating, fiscal and administrative functions of government, and public services such as fire, police, sanitation, tax administration and collection, and water, (2) chief executive officer's expenses-the salaries and expenses of the office of the Governor of a State or the chief executive of a political subdivision, (3) legislative expenses--salaries and other expenses of the State legislature or similar local governmental lawmaking bodies such as county supervisors, city council, etc., and (4) tax anticipation warrants and property tax functions.

2l56.2 Allocation Bases.--Costs allocated to a provider from a servicing governmental unit must fairly represent benefits received by the provider. Therefore, for the following types of services, the following allocation bases are recommended:

TYPE OF SERVICE	BASIS FOR ALLOCATION
Accounting	Time spend on number of transactions processed
Auditing	Direct audit hours

2202.10 Ratio of Beneficiary Charges for Ancillary Services to Total Charges for Ancillary Services Under the Combination Method.--

A. For cost reporting periods starting before January 1, 1972, the ratio of beneficiary charges for ancillary services to total charges for ancillary services, as applied to inpatients, means the ratio of the total inpatient charges for covered ancillary services rendered to beneficiaries of the health insurance program to the total inpatient charges for ancillary services to all patients during a cost reporting period. This ratio is applied to the total allowable inpatient ancillary costs for the period to determine the amount of reimbursement to a provider for the covered ancillary services rendered to beneficiaries.

B. For cost reporting periods starting after December 31, 1971, the ratio of beneficiary charges for ancillary services to total charges for ancillary services, as applied to inpatients, means the ratio of the total inpatient charges for covered ancillary services rendered to beneficiaries of the health insurance program to the total inpatient charges, excluding delivery and labor room charges for ancillary services to all patients during a cost reporting period. This ratio is applied to the total allowable inpatient ancillary costs for the period, excluding delivery and labor room costs, to determine the amount of reimbursement to a provider for the covered ancillary services rendered to beneficiaries.

2202.11 Average Cost Per Diem for Routine Services.--

A. For cost reporting periods starting before January 1, 1972, average cost per diem for routine services means the amount computed by dividing the total allowable inpatient cost for routine services by the total number of inpatient days of care (including intensive care but excluding newborn days where nursery costs are excluded from routine service costs) rendered by the provider in the cost reporting period. (Total number of inpatient days includes any charity and courtesy days of care rendered, and may or may not include employee days in accordance with §332.1.)

B. For cost reporting periods starting after December 31, 1971, average cost per diem for general routine services means the amount computed by dividing the total allowable inpatient cost for routine services (excluding the cost of services provided in intensive care units, coronary care units, and other special care inpatient hospital units as well as nursery costs) by the total number of inpatient days of care (excluding days of care in intensive care units, coronary care units, and other special care inpatient hospital units and newborn days) rendered by the provider in the cost reporting period. (Total number of inpatient days includes any charity and courtesy days of care rendered, and may or may not include employee days in accordance with §332.1.)

C. Average cost per diem under swing-bed reimbursement.--Reimbursement of routine services furnished in a swing-bed hospital is based on separate average per diem costs for routine long-term care services and general routine inpatient hospital services (see §2230.4 A.)

2206. TOTAL CHARGES

2206.1 Accrual.--A provider's total charges used in the ratio of beneficiary charges to total charges should include all charges for services rendered during the entire cost reporting period. Where a provider does not record its total actual charges on this basis, an accrual must be established to provide for any unrecorded charges. This would also include delayed billing charges, i.e., those charges recorded in a subsequent cost reporting period but applicable to services rendered in the current cost reporting period. A provider should be consistent in the method which is used to establish accrued charges at the end of each cost reporting period. See §2805 regarding apportionment statistics for providers subject to the prospective payment system (PPS).

Where the costs of nonallowable services (e.g., costs of television and radio services for the entertainment of the patients where the equipment is located in patient accommodations) are excluded from allowable costs on the Medicare statement of reimbursable costs, the charges for such nonallowable services for all patients should also be excluded from total charges. Where a provider chooses to include the charges for professional services rendered by hospital-based physicians in Medicare and total charges, these charges must also be accrued. (See § 2204.l.)

2206.2 Late Discharges.--Where a provider imposes a charge for a late discharge, it should include such charges in its total charges for all patients. This is required in order to effect the proper apportionment of costs in the Medicare cost reimbursement formula based on the ratio of Medicare charges to total charges. (For cost reporting periods beginning before January 1, 1972.) (See 2205.3 for an explanation of late discharges for Medicare beneficiaries.)

2206.3 Accommodation Differential - Difference between Semiprivate and Ward.--See § 2204.3, Accommodation Differential.

Cost Apportionment

2207. METHODS OF COST APPORTIONMENT FOR PART A INPATIENT SERVICES

2207.1 Objective.--The law provides that the costs of services to individuals covered by the health insurance program will not be borne by individuals not so covered, and, conversely, that costs of services to individuals who are not under the program will not be borne by the program.

The two methods of apportionment (departmental and combination) available for use in determining the cost of services rendered to beneficiaries of the program have as their goal the allocation of the total allowable costs between the beneficiaries and other patients in as equitable a manner as possible. Under these methods, if it is found that beneficiaries receive more than the average amount of services, the providers would receive reimbursement greater than the average cost for all patients. Conversely, if the beneficiaries receive less than the average amount of services, the providers would be reimbursed accordingly for the services rendered.

2208. METHODS OF COST APPORTIONMENT FOR ALL-INCLUSIVE RATE OR NO-CHARGE STRUCTURE PROVIDERS

2208.1 All-Inclusive Rate or No-Charge Structure Hospitals.--The approved methods for apportioning allowable cost between Medicare and non-Medicare patients under the program are not readily adaptable to those hospitals having an all-inclusive rate (one charge covering all services) or a no-charge structure. Therefore, alternative methods of apportionment have been developed for all-inclusive rate or no-charge structure hospitals. These methods are available only to those hospitals which do not have charge structures for individual services rendered. The alternative methods described herein are presented in the order of their preference, A through E.

For cost reporting periods ending before January 1, 1970, the statistical method (Method A) should be used where there are sufficient and usable data available. Alternative Methods B through E are offered to accommodate the varying degrees of data available in these hospitals. The use of Methods B through E must be approved by the intermediary after considering the data available and ascertaining which of the methods that can be applied achieves equity, not merely greater reimbursement, in the allocation of costs for services rendered to Medicare beneficiaries.

For cost reporting periods ending after December 31, 1969, the statistical method (Method A) shall be considered the permanent method of cost apportionment. Where the permanent method is not used, the intermediary may grant specific permission for a hospital to continue to use--on a temporary basis--a less sophisticated method.

Having used an alternative of higher preference, a hospital may not elect to use an alternative of lower preference in subsequent reporting periods. For example, if a hospital used Method D, Comparative Hospital Data, for its first reporting period, it cannot, thereafter, elect to use alternative Method E. It can, however, use methods A, B, or C. Where the statistical method is not used, the intermediary will add to the cost report a statement explaining why the method selected was used, and why methods of higher priority could not be used.

In the application of these alternatives, cost report forms plus associated instructions and definitions currently in use should be used where applicable.

A. Departmental Statistical Data-Method A.--In the absence of charge data which would permit the use of methods approved under §§ 2200.1-2200.3, this method is to be used where adequate departmental statistics are available. The step-down procedures for cost finding required in § 2306.1 must be used.

Under the statistical method, the cost of routine services are apportioned on the basis of the relative number of patient days for beneficiaries and for other patients, i.e., an average per diem basis. The costs of ancillary services if apportioned departmentally on the basis of the ratio of covered beneficiary inpatient statistics to total inpatient statistics applicable to such costs. Statistics must be weighted to reflect relative values. Since weighting factors may vary among various types of institutions, the intermediary may approve the use of those factors which in its judgment produce the most equitable results in each situation. In any event, the data collected must satisfy audit verification. The amounts computed as the program's share of the provider's routine and ancillary costs are then combined in determining the amount of program reimbursement.

Application.--Hospitals that have maintained a count of services by type rendered to Medicare and non-Medicare patients may apply such statistics in the apportionment of ancillary costs. Hospitals that did not record such statistics during their first Medicare cost reporting period may use statistical sampling techniques where approved by the intermediary. However, hospitals that began to record such statistics during the second cost reporting period may use the statistical data gathered in the second period to apportion costs of the first period. In such cases,

however, the intermediary must have established that procedures followed in gathering data are proper. The statistics must represent an adequate segment of the period in which gathered, preferably 6 months or longer.

Certain ancillary services may not be considered sufficiently significant to justify a separate calculation of costs for Medicare and non-Medicare patients. For example, a provider may have very limited physical therapy services which may represent less than 1 percent of the total direct and indirect costs and therefore a separate cost apportionment is not necessary. Other ancillary services such as regular drugs and medical supplies may be significant but present special difficulties in identifying and measuring usage. For cost reporting period ending before January 1, 1970, the total expenditures for such services can be segregated and assumed to have been incurred by Medicare and non-Medicare patients in equal quantity per patient day. The cost of these ancillary average cost per diem for all patient multiplied by the total number of Medicare patient days. For period ending after December 31, 1969, where such services are significant, adequate procedures must be established for measuring the use of these services by Medicare beneficiaries.

Using the statistical basis the cost settlement shall be determined as follows:

1. Determine total allowable cost using Form SSA-1562, Schedule A through Worksheet B-1-2.

2. Complete Schedule C and C-1 Form SSA-1562 to allocate total allowable costs between inpatient and outpatient services using the ratios of total inpatient charges and total outpatient charges to total combined charges, weighted statistics, occasions of service, or other basis with the intermediary's approval.

3. Multiply the average per diem cost of routine services by the total Medicare days, or apply the ratio of Medicare inpatient charges to total inpatient charges to total inpatient routine services costs to determine Medicare's share of routine service costs.

4. Determine the Medicare portion of ancillary costs by applying departmentally, the statistical ratio of Medicare utilization to total utilization. Such statistical data may be shown on the "Calculation of Reimbursement Settlement, Inpatient Services," Form SSA-1563, page 2, for cost reporting periods ending before April 1, 1968, or Exhibit B, Form SSA-1992 for cost reporting periods ending after March 31, 1968.

5. The statistics used in 4 above should be supported by a supplementary schedule showing how they were developed.

2208.3 Determining Cost of Inpatient Ancillary Services Covered Under Part B for Medicare Beneficiaries in Hospitals and Skilled Nursing Facilities with All-Inclusive Rate or No-Charge Structure.--The cost of inpatient ancillary services, which are rendered to hospital or skilled nursing facility inpatients and which are covered under Part B when the level of care becomes noncovered or when Part A benefits become exhausted or are otherwise not payable, must be determined in accordance with the provisions of this section. These ancillary services include radiology, pathology, electrocardiology, electroencephalography, physical therapy (effective October 30, 1972), speech pathology (effective January 1, 1973), renal dialysis (effective July 1, 1973), and prosthetic devices, braces and splints covered under the heading of medical supplies.

Section 2208.1, applicable to hospitals, and section 2208.2, applicable to skilled nursing facilities, prescribe the cost apportionment methods for computing the cost of services which are rendered to Medicare inpatients and which are reimbursable under Part A. Accordingly the methodologies to be used in determining reimbursable Part B inpatient ancillary service costs are dependent upon which of the cost apportionment methods available to all-inclusive rate or no-charge structure providers are employed. These methods are described below.

The procedures outlined in this section have not been specifically directed towards the all-inclusive rate and no-charge structure hospital skilled nursing facility complex. Components of these provider complexes should use the apportionment methods which have been approved by the intermediaries within the guidelines of §§ 2208.1-2208.2. In addition, intermediaries shall adapt the procedures outlined in this section to these provider complexes to assure that reimbursement is equitable. In so doing, such providers should use the form SSA-9554 exhibits which are comparable to the exhibits and schedule of forms SSA-1751 cited throughout this section.

A. Departmental Statistical Data-Method A or Method I.--(For use by hospitals or skilled nursing facilities.) Part A ancillary service costs under this apportionment method are determined by use of statistical data accumulated separately for each department.

To determine the Medicare portion of Part B inpatient ancillary service costs, it will be necessary to accumulate Medicare departmental statistical data, using the same bases as those used for the same ancillary services in determining the Part A costs. Such Medicare statistical data will be

applicable to those beneficiaries covered under Part B when Part A benefits are not payable. the ratio of statistics for Medicare Part B inpatients to total statistics for all inpatients, by department, will be applied to the total allowable inpatient cost for that department to determine the cost which is reimbursable under Part B.

Application.--

a. Determine the Medicare portion of allowable inpatient routine and ancillary service costs reimbursable under Part A, as well as outpatient service costs reimbursable under Part B, according to the format outlined for hospitals in § 2208.1 or for skilled nursing facilities in § 2208.2.

b. Use the ratio of Medicare Part B inpatient statistics to total statistics for all inpatients, by department, to determine the Medicare portion for Part B inpatient ancillary costs. Substituting statistics for charges, this determination may be made on Exhibit F of form SSA-1992. Both hospitals and skilled nursing facilities may use Exhibit F.

c. For hospitals, the total amount applicable to Medicare, which is computed on Exhibit F, column 5, line 7, should be inserted on Form SSA-1992, Exhibit E, column 2, line 6a. For skilled nursing facilities, this amount should be added to the amount computed on Form SSA-1751, Schedule D-2, line 5. The caption on this line should be modified to indicate that such costs are included therein. Also, insert the amount computed on Exhibit F, column E, line 7, to the left of the "Part B column" on line 5. Accordingly, the amount appearing in the "Part B column" on line 5 will be the product of line 4 multiplied by line 3, plus the amount entered to left of the "Part B column."

B. Sliding Scale--Method B.--(For use by hospitals only.) Under this method, an adjusted average per diem Part A ancillary cost applicable to Medicare inpatients is determined by applying to the ancillary service average per diem cost a weighted percentage, which takes into account the longer lengths of stay of aged patients.

The following percentages represent the average ratio of inpatient ancillary service costs, which would be reimbursable under Part B when Part A benefits are not available, to total inpatient ancillary service costs.

All Hospitals Except Psychiatric	45%
Psychiatric	48%

The reimbursable Part B ancillary cost applicable to Medicare inpatients shall be the appropriate percentage times the adjusted average per diem Part A ancillary cost for Medicare inpatients.

Assuming the provider is a short-term hospital, the following illustrates this method for computing the Part B inpatient ancillary service:

2600. PRINCIPLE

For cost reporting periods beginning after December 31, 1973, reimbursement to providers for services to Medicare beneficiaries will be based upon the lower of the reasonable cost of providing those services or the customary charges for the same services. However, in the case of hospital Part A services, this provision will not apply to cost reporting periods beginning on or after October 1, 1982, for any hospital that is subject to the rate of increase ceiling under section 1886(b) of the Social Security Act. The lower cost or charges provision also will not apply with respect to hospital Part A services furnished by a hospital that is subject to the prospective payment system, pursuant to section 1886(d) of the Act for cost reporting periods beginning on or after October 1, 1983. (Providers entitled to recapture previously disallowed costs will continue to be able to do so during this time.)

Payments to providers will be based on the interim rate which approximates reasonable cost as nearly as practicable, but cannot exceed 100 percent of the customary charges for the same services. (See §2406.)

This principle will be applicable to services rendered by providers other than those public providers (see§2604.2) that render services free of charge or at a nominal charge. When such public providers render services to beneficiaries, they will be paid full reasonable cost for those services. (See §2616.)

The lower of cost or charges principle does not apply to SNF-type services furnished in a swing-bed hospital (see §2230.3A). This principle also does not apply to SNF services furnished to inpatients of a distinct part SNF which is part of a qualified small, rural hospital complex that has elected the optional reimbursement method. (See §2230.5)

2602. APPLICATION

Application of the lower of reasonable cost or customary charges provision requires that a comparison be made between the total reasonable cost and the total customary charges of the items or services furnished Medicare beneficiaries. In comparing charges and cost, all customary charge for items and services and the reasonable cost of such items and services will be aggregated without regard to whether the related provider services are reimbursable under Part A or Part B of title XVIII. (See §2610.)

In a cost reporting period where a provider's aggregate customary charges are less than its aggregate reasonable cost, payment to that provider will be based on its charges. However, under certain circumstances, a provider may carry forward its unreimbursed reasonable cost for reimbursement in a subsequent cost reporting period. Amounts carried forward may be reimbursed in the next two succeeding period. Amounts carried forward may be reimbursed in the next two succeeding periods, but only to the extent total customary charges exceed total reasonable cost in each subsequent period. (See §2614.)

2604. DEFINITIONS (Also see §2402.)

2604.2 Public Providers.--A public provider means any provider owned by a Federal, State, county, city, or other local government agency or instrumentality. This definition includes facilities owned jointly by two or more Government entities but does not include facilities owned jointly by Government and private organizations.

2604.3 Customary Charges.--Customary charges are those uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement. Where a provider does not have an established charge schedule in effect and applied to most patients, the determined "customary charges" are the most frequent or typical charges imposed uniformly for given items or services. However, in either case, in order to be considered customary charges, they must actually be imposed uniformly on most patients and actually be collected from a substantial percentage of "patients liable for payment on a charge basis." Such charges must also be recognized for program reimbursement.

A. Imposed Uniformly on Most Patients.--To be considered "customary" for Medicare reimbursement, a provider's charges for like services must be imposed on most patients regardless of the type of patient treated or the party responsible for payment of such services.

2. Stratification of Collections from "Patients Liable for Payment on a Charge Basis.--The provider's accounts receivable record should indicate the party responsible for payment and similar classification should be identifiable within those records. The provider should segregate and analyze the changes to those individuals "liable for payment on a charge basis" as described in l above. The analysis should identify the patients, the charges, amounts collected, bad debts, etc.

3. Bad Debts and Indigency Allowances of "Patients Liable for Payment on a Charge Basis.--Where bad debts and/or indigency allowances constitute the provider's reason for not collecting the charges imposed from its established charge schedule, reasonable collection efforts must be made by the provider, within the criteria set forth in §§3l0 and 3l2, these charges to be considered "customary charges." (Public providers, see § 2606.2E.)

2604.4 Nominal Charges.--A public provider's charges are considered nominal where the aggregate customary charges (see § 2604.3) are less than one-half of the reasonable cost of services or items represented by such charges. Nominal charges are charges which are usually token in nature and not intended to be full reimbursement for the items or services furnished.

Determination and Comparison of Customary Charges and Reasonable Cost

2606. DETERMINATION OF CUSTOMARY CHARGES FOR COMPARISON WITH REASONABLE COST (see § 2604.3.)

Each provider and subprovider must separately make a determination of its customary charges; for example, when a hospital and its distinct-part SNF are both participating providers, each must make such a determination of customary charges for its own operation.

Where a provider imposes its charges uniformly and actually collects its charges from a substantial percentage of "patients liable for payment on a charge basis", the provider's charges, whether from an established schedule or its most frequent or typical charge, are considered to be its customary charges. These should be compared to reasonable cost, as provided for in § 26l2, to determine the amount of Medicare reimbursement.

However, where a provider does not actually impose its charges uniformly or fails to make a reasonable effort to collect its charges from a substantial percentage of "patients liable for payment on a charge basis" (see § 2604.3B), the provider's charges, whether from an established schedule or its most frequent or typical charges, are not considered to be customary. Instead, those charges must be adjusted as directed in § 2606.2 in determining customary charges for Medicare reimbursement purposes.

Example No. 3

A. An analysis of charges disclosed the same information described in Example No. l above.

B. An analysis of collections from "patients liable for payment on a charge basis" disclosed the following:

l. The individuals with private insurance made only partial payment of the charges imposed. This payment was accepted by the provider as full payment for services rendered the covered patients with no further collection efforts employed.

2. The remainder of the "patients liable for payment on a charge basis" had no insurance coverage, and the difference between charges and collections was due to bad debts even though reasonable collection efforts were employed by the provider.

C. Customary charges for comparison with reasonable cost are computed as follows:

$$\$l00{,}000 \times \frac{\$270{,}000 + \$l0{,}000(*)}{\$300{,}000} = \$93{,}330$$

(*) Represents bad debts where reasonable collection effort has been made.

2606.2 Treatment of Providers with Special Charge Structures.--The methods for determining customary charges for providers which have special charge structures are as follows:

A. No-Charge Structure.--Generally, if a provider other than a public provider does not charge for services rendered in the delivery of health care services, there are no customary charges related to such services, and the Medicare program will not reimburse for such services. Public providers, which furnish services free of charge, are reimbursed the reasonable cost of services.

B. All-Inclusive Charge Structure.--If an "all-inclusive rate" structure is uniformly applied to all patients, those charges may be used for determining customary charges under the lower of cost or charges provisions. An "all-inclusive rate" is generally:

l. A single rate for all services based on:

a. A per diem rate, or

b. Patient's illness, injury or type of treatment, or

c. The type of accommodation.

2. A single rate for most services with separate charges for a very small number of separate specialized services.

Some providers using an "all-inclusive rate" may be public providers and will be reimbursed reasonable cost if their charges are less than 50 percent of the cost of delivering health care services.

C. Descending-Rate Charge Structure.--The descending-rate is predicated upon the length of patient stay; that is, the longer the patient stays, the lower the charge per day (regardless of the type of service rendered). If the descending-rate charge structure is uniformly and consistently applied to all patients, these charges will be considered the customary charges for purposes of this section.

D. Sliding-Scale Charge Structure.--Some providers offer free care or care at a reduced charge to patients who are determined to be financially indigent. This practice may reflect the provider's written policies or the requirement of a Hill-Burton agreement to provide free care. In such cases, the charge assessed the patient is based on the patient's ability to pay. Under program guidelines, the difference between the provider's full published charges and the charge actually assessed the patient is considered an indigency allowance. To assure that the provisions of such free are or care at a reduce rate will not affect the acceptance of the provider's established charge schedule as customary (public providers, see § 2606.2e), the following conditions must be met:

l. The provider must have a published schedule of its full (nondiscounted) charges.

2. The provider's revenues for patient care must be based on application of the published charge schedule.

3. The provider must maintain written policies for its process of making patient indigency determinations.

4. The provider must maintain sufficient documentation to support the amount of "indigency allowances" written off in accordance with the above procedures.

E. Public Providers with a Sliding Scale Charge Structure.--Some public providers establish a sliding-scale structure pursuant to a legal requirement imposed by a State or local government or as a condition of a Federal grant or loan. This requirement stipulates that the charge billed must be based on the patient's or responsible party's ability to pay or it may require the provider to render free care to medically indigent patients.

A public provider with a legally-required sliding-scale charge structure may elect to determine Medicare aggregate customary charges by : (l) meeting the conditions in § 2606.2D so that its full rate from its established charge structure will not be affected, or (2) applying the formula contained in § 2406.1A, or (3) applying the ratio of the actual charges billed to patients liable for payment on a charge basis (non-contractual patients) based on the sliding scale, to the adjusted charges to noncontractual patients based on the charge schedule used to record charges on bills submitted for program reimbursement applied to Medicare aggregate charges, or the ratio of billed charges to non-contractual patients to total charges recorded for noncontractual patients applied to Medicare aggregate charges.

EXAMPLES:

Option 3 (1st Alternative)

1	a--Medicare aggregate charges	$ 500,000	
	b--Actual charges to noncontractual patients based on sliding scale	200,000	
	c--Adjusted charges to noncontractual patients based on the charge schedule used to record charges on bills submitted for program reimbursement	1,000,000	
2	a--Actual charges (line 1b)	$ 200,000	
	b--Adjusted charges (line 1c)	1,000,000	
	c--Ratio of a + b		20%
3	a--Medicare aggregate charges (line 1a)	$ 500,000	
	b--Ratio (line 2c)		20%
	c--Medicare aggregate customary charges	$ 100,000	

Option 3 (2nd Alternative)

1	a--Medicare aggregate charges	$ 500,000	
	b--Total charges recorded for noncontractual patients before medical indigency allowances	1,000,000	
	c--Medical indigency allowances	800,000	
2	a--Total charges (line 1b)	$1,000,000	
	b--Medical indigency allowances (line 1c)	800,000	
	c--Billed charges	$ 200,000	
3	a--Billed charges (line 2c)	$ 200,000	
	b--Total charges (line 1b)	1,000,000	
	c--Ratio of a – b		20%
4	a--Medicare aggregate charges (line 1a)	$ 500,000	
	b--Ratio (line 3c)	20%	
	c--Medicare aggregator customary charges	$ 100,000	

2612. COMPARISON OF CUSTOMARY CHARGES AND REASONBLE COST

Application of this provision requires each provider and subprovider to make a comparison between the customary charges and the reasonable cost, as described in the related preceding subsections. Consequently, a hospital with a distinct-part SNF, where both are participating providers, must make separate determinations for the hospital and for the SNF as to which is lower--its customary charges or its reasonable cost.

made after the current basis for payment has been determined, i.e., reasonable cost or customary charges.

C. Payments to funds for donated services of teaching physicians.

D. Administrative costs incurred after a provider terminates participation in the Medicare program and which are included in the final cost report as provided for in §2176.

E. Costs representing unanticipated extraordinary expenditures made by a provider immediately following the end of the provider's final cost reporting period for unemployment compensation paid to former employees. The unemployment must be en masse and attributed to the provider's simultaneous cessation of operations and termination of program participation. The cost must be properly includable in the provider's final cost reporting period based on its system of accounting for such costs.

F. Costs incurred by a provider before cessation of operations and termination of program participation, but which are represented by a subsequent lump-sum pension plan payment related to the employees' prior services to the provider. The subsequent lump-sum payment must be caused by the cessation of operations and the provider must be legally required to make such payment.

G. Reasonable accrued severance pay due to a provider's cessation of operations and termination of program participation. Severance payments made to individual employees in an ongoing operation are not excluded from the comparison of reasonable cost to customary charges.

Reasonable cost, for comparison with customary charges, should include the allowance for return on equity capital permitted for proprietary providers as provided for in Chapter 12.

After all exclusions and limitations have been applied to otherwise reasonable and allowable costs, including the specific adjustments mentioned above, the remaining reasonable cost should be compared to customary charges as described and illustrated in §2612. Adjustments to reasonable cost other than those specified above may not be made.

2610. AGGREGATION OF CHARGES

For purposes of determining payment under the lower of cost or charges provision, the provider should aggregate its customary charges for all items and services furnished Medicare beneficiaries regardless of whether the related items or services are covered under Part A or Part B of title XVIII. In order to be comparable to these customary charges, the reasonable costs for items or services furnished Medicare beneficiaries should also be aggregated without regard to whether those costs would be reimbursable under Part A or Part B. Customary charges and reasonable cost are subject to the adjustments described in §§2606 and 2608, respectively, prior to their comparison. In addition to those adjustments, however, the provider should assure itself that it has reduced both its charges and costs for (1) the professional component (see §2108) of its provider-based physicians, and (2) all items and services not covered by Medicare.

See the FACTS for examples in §2612 for an illustration of the aggregation of charges for comparison with reasonable cost.

Total Medicare Payment

Total Medicare reasonable cost	$687,000
Amount of Cost Limitation carryover actually recovered (maximum available $5,000, maximum applicable this period $3,000)	$ 3,000
Subtotal	$690,000
Amount of Lower of Cost or Charges carryover actually recovered (available $7,000 maximum, if available, $13,000, less actual Cost Limitation carryover $3,000 recovered equals $10,000)	$ 7,000
Total Medicare payment*	$697,000

*Less: Interim payments, etc. already paid by Medicare to its beneficiaries.

Amounts available for carryover (To Next Reporting Period)

Cost Limitation ($5,000 Less recovery of $3,000)	$ 2,000
Lower of Cost or Charges ($7,000 less recovery of $7,000)	$ - 0 -

Public Providers

2616. PUBLIC PROVIDERS

A public provider, as defined in § 2604.2, with a no-charge or a nominal-charge structure will receive payment for items or services furnished Medicare beneficiaries based on reasonable cost. Only a pubic provider with a no-charge or nominal-charge structure, as defined in § 2604.4, is exempted from the lower of cost or charges application. When a public provider does not charge for services furnished, there is no basis for making the comparison and payment to such a provider will be the reasonable cost of providing such services. However, when a public provider imposes nominal charges for services furnished, a comparison of the provider's aggregate customary charges and aggregate reasonable cost (see § 26l4) shall be performed to determine the basis for payment.

If the comparison substantiates the charges as being nominal, i.e., less than 50 percent of reasonable cost, the public provider will be entitled to payment of the reasonable cost, the public provider will be entitled to payment of the reasonable cost for such services. On the other hand, if the aggregate charges are determined to be other than nominal, the provider will receive payment based on the lower of its customary charges or reasonable cost. Where a public provider is reimbursed on the basis of charges, it is entitled to utilize the carryover recovery provisions set forth in § 2614.